Proceedings

Senior Consultation on Reproductive Health

June 4, 5, and 6, 1997

Sponsored by USAID

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Senior Consultation on Reproductive Health

Introduction

The Senior Consultation on Reproductive Health was held on June 4 - 6, 1997. The meeting was sponsored by USAID's Nutrition and Maternal Health Division to explore two issues vital to implementing sustainable, client-centered reproductive health services and to creating an enabling environment for behavior change:

- How to improve and maintain the quality of reproductive health (RH) services?
- How to increase demand for these services?

Under the guidance of six senior consultants, participants shared "lessons learned" from interventions and research findings that focus on increasing the quality and utilization of services. The sessions included presentations from the senior consultants, "voices from the field", large group discussions and small working groups. Over forty health and development specialists debated what is known and what must be learned to implement quality reproductive health services that will be valued by consumers. The Consultation provided a forum where professionals, committed to the concept of reproductive health, could share and increase their knowledge, and develop recommendations that will inform present and future RH programming in the USAID PHN Center.

Consultation Goal and Objectives

The goal of the Senior Consultation on Reproductive Health was to "help USAID's PHN Center to improve and maintain the quality of care of reproductive health services in developing countries and to increase demand for these services."

The objectives of the Senior Consultation were to:

- develop recommendations on how USAID, through the PHN Center and its projects, can maintain and improve the quality of care of reproductive health services;
- recommend how USAID, through the PHN Center and its projects, can increase demand for reproductive health services;
- identify remaining issues requiring further research; and,
- produce proceedings that document these recommendations to be used to inform ongoing PHN projects and to serve as a resources for future PHN Center reproductive health project design efforts.

Background

Each year nearly 600,000 women, 99% from developing countries, lose their lives during pregnancy and childbirth. The majority of these deaths, caused by hemorrhage, sepsis, obstructed labor, eclampsia and the sequelae of unsafe abortion, are largely preventable with known technologies. Millions more suffer direct and long-term complications of pregnancy and delivery.

Larger still are the numbers of women who live with the discomfort and dangers of reproductive tract infections--and the potential for increased transmission of the HIV virus--and suffer from micronutrient deficiencies and protein/calorie undernutrition. Two million girls are at risk each year for female genital mutilation and its associated medical complications. In addition, many women do not yet have access to methods for spacing or avoiding further pregnancies.

In addition to these important women's health concerns, the health and nutritional status of mothers also has a profound impact upon the health of newborns. In the developing countries where infant mortality has been reduced, close to one-half of residual infant deaths occur during the neonatal period. Many of these deaths result from complications of labor and delivery or from low birth weight due, in part, to maternal undernutrition or infection.

And when childbirth results in death of the mother, the infant's chances of surviving the first year of life are extremely poor; worse if the child is female. As might be expected, most interventions designed to improve maternal health and nutrition have positive effects on infant health and nutrition.

Ten years after launching the Safe Motherhood Initiative and three years after the ICPD's call for a programming shift to client-centered reproductive health, the international health and development community continues to grapple with the issues of quality of care, and utilization of services. Where reproductive health services are available they are often of such inferior quality that health outcomes are poor and utilization is low. Other factors that contribute to facilities with providers but few clients are client-perceived cultural barriers and the inability of women to access services due to their low status and disempowerment.

Underutilization, in turn, impacts on the sustainability of services, particularly when clients and communities were not involved in problem identification, project planning and implementation. Such programs often die out when donor funding ends.

There exists, however, a growing body of applied and operations research directed toward finding successful approaches to the issues of improvement and maintenance of quality of care, and demand generation. The Senior Consultation was organized to contribute to this global focusing by examining the "lessons learned" to date and by making recommendations for closing the existing knowledge gaps or scaling up where warranted.

Results

Program sessions were informative and provocative, often engendering lively discussion. One area of particular interest was the role of IEC and behavior change techniques vis-à-vis activities that focus on social change, such as community organization and mobilization. Another area of interest dealt with who has responsibility for prioritizing RH services--donors, governments, NGOs, community, or clients. It is important that these debates continue.

By the end of the consultation certain themes were clearly recurring and underlie all of the recommendations that follow:

- Communities should be involved in the planning, monitoring and evaluation of programs.
- Programs should strive to engage women as participants, not just recipients.
- Quality should be defined by both the client and the provider.
- Health should be addressed within the social context (poverty, illiteracy, violence, disempowerment).

Though commitment and effort ran high for both consultants and participants, there was insufficient time to produce a more synthesized, "definitive" list of recommendations on these topics. Nor was there time to prioritize the recommendations. It was felt that groups within the PHN Center that have been tasked with expanding the RH portfolio, such as the RH Interest Group, would be well suited for this. Thus the recommendations should be seen as a contribution to a larger ongoing effort.

Following the Recommendations below, are the briefs submitted by the Senior Consultants based on their panel presentations. Also included are the Agenda, the Participants List and Illustrative Discussion Questions--prepared to guide the small group discussions. In many cases, these questions were not addressed due to time constraints, but may provide thought for future discussions on quality of care and demand generation. Recommendations from a MotherCare meeting on quality of care and training are also included.

In sum, the Consultation and Proceedings represent one step in the ongoing process of ensuring that USAID projects are responsive to the needs of their clients in the developing world. Those of us who organized this meeting hope the recommendations are useful for future PHN programming and policy efforts, in order to make the concept of client-centered, integrated reproductive health services a reality, and to increase the health and well-being of women in the developing world.

Recommendations

Quality of Care

PHN projects must foster a "culture of quality" where providers view quality as a primary objective of their work and clients expect and feel entitled to quality services. In order to accomplish this, projects should:

Training

- Incorporate concepts of managing for quality in all staff training, including how to collect and use data for problem solving/decision making.

- Base curricula, for pre-service and in-service training in the prevention and treatment of RH conditions, on nationally developed or refined protocols.

- Improve or establish competency-based medical, nursing and midwifery pre-service training. Place program emphasis on pre-service rather than in-service training.
- Expose students to community health issues and community-based medicine early in their training. Explore the possibilities of linking students with traditional healers/birth attendants for a "rotation" while still in training.

- Include, in pre-service medical and nursing training, topics on IPC--treating clients with dignity, compassion and respect--involving all relevant ministries and students in the design of these curricula.

Monitoring and Evaluation

- Evaluate the quality of services with process indicators while continuing to develop realistic, measurable outcome indicators.

- Adequately monitor and supervise provider performance based on compliance with agreed-upon standards and protocols.

- Empower health worker teams to choose indicators for self monitoring.

- Increase the understanding of self assessment: what kinds of methodologies exist? Is self assessment more cost effective than external methods of monitoring? Does it lessen the need for supervision?

- Strengthen and build capacity in professional healthcare associations so that they can provide continuing medical education opportunities and monitor the quality of services provided by their members.

Service Delivery

- Ensure that project health facilities have the necessary equipment and supplies, diagnostics, and therapeutics to provide quality care. This capacity is fundamental to establishing and maintaining consumer confidence and is particularly crucial when dealing with obstetric emergencies.

- Build "Quality Teams" at the District level to maintain provider motivation, foster supportive supervision, and to improve links between frontline workers in the community and at health posts/ centers, and the referral hospital.

- Support the concept of a "Mother Friendly Hospital" program currently being developed by UNICEF.

- Conduct research on the role and composition of the private sector in each area where PHN is initiating/implementing programs to better understand issues of coverage, access and quality.

Policy

- Establish, at the national level, an in-country coordinating body made up of all relevant ministries, professional organizations, NGOs and community/consumer groups, that determines RH priorities for that country, taking into consideration available resources and community expectations. All international and bilateral agencies should work through this body. (Accepted from MC Recommendations.)

- Work with all stakeholders, including MOHs and professional organizations, to formulate or revise policies, standards and protocols for clinical care and counseling of reproductive health conditions.

- Work with MOHs and community groups to develop policies/incentives to ensure that well-trained providers are deployed/attracted to rural areas.

- Promote policy reforms that allow appropriately trained providers (medical or non medical) to perform medical procedures at the periphery, so long as they can be carried out safely and providers are held accountable.

- Work with governments, consumer groups and professional organizations to develop mechanisms for holding public *and private* sector institutions and providers accountable, eg recertification, accreditation.

Client/Consumer/Community

- Explore all possible avenues for increasing consumer/community involvement (including marginalized populations) in the design, implementation and monitoring of RH programs.

- Enhance consumers' expectations of and demand for quality services through community mobilization and education (including health rights education), and by providing options or choice in care.

- Identify points where treatment decisions can be shared with the consumer. Does this enhance client satisfaction? Provider satisfaction?

- Guard against client coercion through consumer health rights education, staff training, and implementing informed consent procedures where appropriate.

- Refine and test methodologies for assessing client satisfaction with care.

- Develop and test methodologies for measuring and understanding community (including all stakeholders) expectations and perceptions of quality, eg participatory research.

- Include "opportunity costs for accessing services" as an important element of quality of care, with programs making all attempts to bring appropriate care as close to the consumer as is practical and cost-effective.

- Conduct research on the ways in which quality of care and demand for care are mutually reinforcing and under what conditions.

Demand Generation/Increasing Utilization

PHN projects should:

- Involve clients/communities in identifying and prioritizing their healthcare needs and the reproductive health (RH) services necessary to meet those needs.

- Recognize that IEC campaigns and social marketing techniques are useful strategies that target the client/community but should not define the process of community involvement/mobilization.

- Integrate RH services to cut down on client opportunity costs and missed opportunities, while reaping operational synergies.

- Acknowledge community identified issues (eg, poverty, literacy, violence) and, if not in the manageable interest of the project to address these issues, facilitate linking/collaboration with other NGOs/programs that can.

- Support approaches that involve women in ways that build their confidence and assertiveness. Develop indicators to measure this. (PHN may need to learn from the experiences of other sectors.)

- Where possible, pro-actively train and employ women in all aspects of health services, resisting programming or supporting partner organizations that use women as volunteers and men as paid workers.

- Allow sufficient time (7 yrs + 7 yrs) for project implementation and evaluation. Community involvement and collaboration take time, as does behavior change.

- Undertake large scale social marketing campaigns when we know that interventions are effective, eg, hand washing for deliveries, tetanus toxoid, Fe folate, exclusive breastfeeding, warming the baby, FP.

- Conduct behavioral and gender analyses as part of the formative research undertaken prior to project design. These data are also needed to inform IEC and social marketing activities developed to promote selfcare and the appropriate utilization of services.

- Further test various approaches and strategies to increase utilization, including:

  -Identification of non-medical incentives for behavior change

  -Clarification of what consumers really value in a service being offered

-Ways to capitalize on and measure the "empowerment" component of an intervention

-The role of payment for services

-The "child to child" approach to behavior change

- Draw from the experiences of other sectors (agriculture, water and sanitation, economic development, education/literacy, etc.) regarding "lessons learned," strategies and approaches to mobilizing communities, including how to measure changes in confidence and empowerment.

- Include advocacy as a critical program element at community, program, and governmental levels.

- Conduct qualitative research on why women (and men) prefer traditional medical practices and explore how those that are harmless or beneficial might be incorporated into the project's RH services.

Senior Consultant Presentations

Demand Generation

Demand Creation Issues and Their Relation to Quality. The SC/US Malawi Experience
Marcie Rubardt, Senior Consultant

Demand Generation in Nepal. The CEDPA/Nepal Experience
Nancy Russell, CEDPA/Nepal Country Representative

Demand Generation and Behavior Change
Kim Winnard, Senior Consultant

Quality of Care

Quality of Care in Reproductive Health
Barbara Kwast, Senior Consultant

Quality in Reproductive Health Care
David Nicholas, Quality Assurance Project Director

The Marriage of Health and Human Rights: Challenges for Service Delivery
Jodi L. Jacobson, Health and Development Policy Project Co-Director

Demand Creation Issues and Their Relation to Quality

The SC/US Malawi Experience *Marcie Rubardt, Senior Consultant*

This paper highlights strategies and issues in mobilizing community demand for reproductive health (RH) services, drawing on the SC/US experience in a community based RH program as well as health programs in child survival, HIS, and orphan support in Mangochi District in Malawi. It then goes on to look at the role of the community in defining and demanding quality of care. With respect to the latter, it proposes that mobilization of demand needs to also lead to the definition of key quality issues and the establishment of mechanisms for communities to interact with their health centers on service delivery issues.

SC/US Health Program in Malawi

The RH program funded under the JSI/STAFH project in Mangochi District takes a multi-sectoral, integrated approach to family planning, sexually transmitted disease (STD) control, and HIV prevention. It is targeting 350,000 people in communities surrounding 10 health centers, 65 primary schools, and 17 secondary schools. Specifically, it carries out the following activities to increase demand in the communities in which it works:

- Train community groups (women, men, and mixed) as community educators, family planning promoters, and peer counselors for RH.
- Train primary and secondary school adolescents and "patron" teachers in HIV/AIDS and FP knowledge and peer counseling skills.
- Expand the role of the Ministry of Health and Population (MOHP) Health Surveillance Assistants (HSA) to provide basic FP education and services in communities.
- Carry out operations research to assess the relative advantage of using volunteer community based distributors versus using HSAs for community level FP services.

Concurrently, the project seeks to improve service delivery through training and supervision of health center staff in FP provision, syndromic management of STDs, and providing support for the community counseling activities.

The health program also includes the COPE project (Community Options for Protection and Empowerment) which works with fewer communities in more depth to identify and address the needs of households caring for orphans. It carries out interventions in small-scale enterprise, HIV prevention, psychosocial support, health tracking, and home based care.

Lastly, there has been a joint effort with the MOHP in the District to implement a Community-Based Monitoring project to collect data at the community level, analyze and feed it back immediately, then to use it for planning purposes at the community and health center levels. This has provided a forum for the MOHP HSAs to discuss health issues with the community.

Issues and Lessons Learned

Achieving more effective community mobilization, ownership, and behavior change on a large scale is an ongoing process. While SC/US does not have definitive answers or conclusions, there are several areas where key issues have been identified and some lessons have been learned.

Community Participation in Health Activities:

In the SC/US Malawi projects, communities are involved with the provision of health services through:

1. the involvement of village health committees in oversight of health activities in the village,
2. community volunteers working as community based distribution agents and family planning promoters,
3. women and men working in groups on HIV prevention and peer counseling activities, and
4. volunteer management of drug revolving funds.

However, motivation and incentives for continued work; supervision and consistency in messages and activities; and the high level of inputs required to recruit, train, and maintain such community participation continue to be a dilemma. Activities such as the drug revolving funds have proven easier to sustain because they come closer to meeting the communities' perceived need whereas reaching the point where the community is actually ready to support a FP volunteer requires much more initial education and mobilization.

Given these problems, a social marketing approach becomes a tempting solution/substitution for community-based mobilization. While it can be an extremely effective tool to raise awareness and achieve name recognition and knowledge, it probably needs to have the complement of more personalized interventions such as from the health workers or community peers. The PSI Chishango campaign in Malawi has been extremely successful at achieving name recognition and desensitizing condoms, yet people still indicate they listen to their health workers or their friends for advice.

B. Community versus Health Center-Based Services:

Easy access is the obvious benefit to providing community-based family planning, STD recognition and referral and HIV counseling services. It is assumed that if services are brought to the doorstep, people will be more likely to use them. Indeed, FP acceptance has significantly increased in the project area with the introduction of Depo-Provera into the community, indicating that there was probably a large unmet need due to women's inability to get to the health center for services. However, problems of consistent supply, supervision, reliable quality of service, training, and the need for incentives inevitably present themselves.

There are several possible directions for the resolution of some of these issues:

1. With adequate mobilization and education (demand creation) actual services may not be necessary at the community level. SC/US is carrying out an operations research on this right now; but it appears that until demand is established, community level services may be necessary. This may be similar to the Zimbabwe experience where paid CBDs were used to

distribute contraceptives in the early phases of its program but now a depot holder model may be sufficient.

2. Integration of FP services with existing under five services – particularly at the level of village outreach, leads to decreased opportunity cost for service utilization on the part of women as well as their being able to attend clinic without its being obvious they are seeking FP services.
3. Lastly, changing the way services are "packaged" in order to make FP/HIV prevention services more desirable and/or including them with more desirable services such as EPI or antenatal care may also draw women into services.

C. Strategies that Involve Men:

Child survival programs have traditionally targeted women and children. By extension, as they have moved into HIV prevention, family planning and safe motherhood, they have continued targeting women; yet men often make the decisions around when to seek help during labor, seeking STD treatment, use of contraceptives, and use of condoms. While preliminary, SC/US is finding that men ARE responsive to population pressure as a motivation to use FP, and their concern about side effects – particularly decreased fertility is a significant barrier to acceptance. As a result, a male motivation approach is proving successful in increasing FP use.

D. Defining Need:

Perception of need is determined by a continuum ranging from culturally determined priorities, to expectations based on past experience of what is possible or normal; to Western science's definition of best practices. For example, the expectations of the women's health care system on the part of a girl reaching adulthood in Malawi are very different than those of a girl in the U.S. – with respect to FP availability and use, normal pregnancy care and risk, and even perceived choice in avoiding HIV infection. These differences result from different levels of knowledge (e.g. the importance of regular and ongoing ANC including a vaginal exam or the actual risks of contraceptive use); differences in possible or normal practice; (e.g. whether an ultrasound is done on pregnancies in women over age 35) and different cultural expectations (e.g. a woman's right to negotiate the safe sex practices of her husband or the acceptability of FP). Finally, Western science tends to become the over riding component in projects' definition of people's need, but may not be consistent with these other determinants.

E. Broadening the Scope – Intervention for Empowerment:

It is documented that literate mothers have healthier children. The necessary research has not been done to document the same phenomenon with other health behaviors, nor is it really known what it is about literacy that leads to the change in children's health. However, the Mangochi program is experimenting with using women's literacy groups as a forum for encouraging safer sexual behaviors and seeking of women's health services. The hypothesis is that it isn't literacy per se, but rather a transformation that occurs in the learning process that leads to behavior change.

The Relationship Between the Provider and the Consumer – What Is Demanded? What Is Provided?

As demand for services increases through a community mobilization process, it becomes important to also assess the scope and quality of the services being provided. While quality assurance (QA) is not the topic of this paper, the role of the community in the definition and monitoring of quality of care is the point where these two topics overlap. There is more to quality than training, and there is more to demand than IEC. They depend on a dynamic interaction whereby quality indicators become mutually defined and monitored. The reference article (Chase & Carr-Hill; "The Dangers of Managerial Perversion: QA in PHC": Health Policy and Planning: **9**(3): 267-278.) argues that in order for QA to work in the PHC context, there has be to a community-based, bottom up approach to QA. This implies working with the community to define indicators that are both culturally sensitive and scientifically sound, then establishing a process where the community is involved in both monitoring and the implied management adjustments.

In Malawi there are significant barriers limiting communities' demand for quality. These include an attitude that they can't change anything anyway; a gender bias leaving women (often the consumer) in a secondary role; lack of geographical, cultural, or age specific (such as the special needs of adolescents) access; and finally lack of knowledge regarding what they should be expecting. SC/US has been discussing the role of community involvement in the ongoing health service delivery with some of the communities with whom it is working. There is interest in establishing committees that would include the village headmen to work with the health center staff both to solve problems and to review surveillance data. This would then provide the forum for introducing an interactive QA process.

What Is Needed from Mothercare

There are two key areas where programs such as the one in Malawi need assistance. The first is continued research on the best, most cost effective practices for rural RH. This included the epidemiologic review of different interventions and outcomes, adequate testing of protocols, and provision of guidance and scientific support for taking more technical services further out to the periphery. Conversely, PVOs have a lot of practical experience needing additional documentation and adaptation to scale if the maximum benefit of their efforts is to be realized. Assistance in the definition of questions and research design for operations research in the implementation of approaches such as the QA process suggested in this paper, community data management, or working to answer some of the issues raised in section two of this paper would be welcome. In this way, Mothercare can continue to expand its role as "clearinghouse" for safe motherhood and reproductive health activities.

Overhead

Overhead

Demand Creation in Nepal

The CEDPA/Nepal Experience *Nancy Russell, CEDPA/Nepal Country Representative*

Demand Generation and Behavior Change

Kim Winnard, Senior Consultant

Outline

1. Introduction: I'd like to begin my presentation by covering health communications' role in increasing utilization of services. It is only a role; quality of care (which you will hear about from other speakers) is a key component to increase and sustain use of services and products. The glue that is needed to keep these two components bound is a care-seeking behavior change approach. That is where my presentation will end up.

2. Health Communications: Health communications comprises the promotion of information, services and products surrounding behaviors that lead to healthier outcomes. This is done through a process of developing key messages and activities delivered through an appropriate mix of electronic, print and traditional media; interpersonal communication such as counseling and outreach; and community-based advocacy and promotion.

As health communication professionals interested in care-seeking (and other) behavior change, we try to create awareness and urgency; provide information and choice; stimulate want and desire; hawk brand and outlet; transfer skills and standards. We can accomplish the following:

--inform and motivate pregnant women, their families and communities to use appropriate self-care;

--increase coverage of health services, facilities and products by improving awareness of its access, making its use better understood and more desirable;

--ensure a degree of compliance with coverage by emphasizing the benefits of timely and routine use or consumption and alerting people to the consequences or side effects of complying or not complying;

--strengthen the human contact between health providers and women, among health providers, and between women, their peers and their communities.

Health communications can also be life-saving when it focuses on the following:

--timely recognition of danger signs and complications, the first step to moving a woman to a higher level of care. These signs may be recognized but taken for granted, as a "normal" occurrence (e.g., swelling of the face) during pregnancy or delivery. Or differing levels of danger may be recognized (e.g., the difference between heavy and light bleeding).

--timely decisions about what to do once the danger is recognized. Being prepared for such a scenario, and enabling a woman's family or TBA (the decision-makers) to make or support those decisions is vital.

--timely movement following decisions are crucial. Availability, location, cost, transport, perceptions about the service's staff, competence and cultural sensitivities, and unforeseen

circumstances will help determine whether movement will occur. Communications here can drive home the point that a woman's life is worth the cost and worth overcoming the barriers.

Now we are venturing into quality of care. Unless the formal health sector (for example, the public sector) competes with a woman's and her community's perception of quality of care and begins to shape products and services to first meet the interests and needs of women rather than providers, women will continue to rely on what they have been relying on for generations--traditional and informal health care, including self-treatment, which in their eyes offers better care, but perhaps not better health outcomes. Health communications does address quality of care through interpersonal and counseling skills training, but there is so much more involved.

3. Care-seeking factors (overheads on Africa and USA): Let's take a quick look at some factors that affect care-seeking behavior of women. On the Africa overhead, I've highlighted with shaded boxes those factors that traditionally are addressed by health communications, whether mass media, outreach, counseling. The USA overhead shows some similarities with Africa (provider attitudes, knowledge regarding pregnancy) and more unique situations (substance abuse, Medicaid). As you can see, there are factors that can't be addressed by communications, and there are factors that can't be addressed by health interventions as well.

4. Care-seeking considerations: Women seek care. It just may not be the care that the formal health sector offers, but they do seek and pay for and go back to services and products. The health outcome, however, may be less than desirable. These three points--competition, negotiation and integration begin to link increasing utilization with quality of care, link a woman's care-seeking behavior with a provider's care-giving behavior, and link a woman's continuance of that behavior to her peers and community. Private sector initiatives, social marketing, participatory development programs are appropriate to discuss at this juncture, since public sector health care can do only so much. The bottom line is that the interventions developed to address utilization of care are behavior-driven.

5. SOS Community Advocacy: This SOS from a Nova Scotia community is a good example of when mainstreaming maternal health has been achieved. It also shows us that, despite our best efforts to improve care-seeking behavior, things happen--budget cuts, personnel and equipment cuts, weather, transport, politics.

6. Finally, I'd like to end with what I think are tenets for us to work with in the next few days (overhead on behavior change tenets). These tenets have emerged from social marketing, health communication, IEC, behavior change lessons learned, including those from the past nine years of MotherCare.

UNDERSTAND BEHAVIORS BEFORE MAINTAINING OR CHANGING THEM

What women gain (perceived benefits) from changing a behavior, what others think and do (norms), what women risk by doing or not doing, whether a woman believes she can do a certain behavior and actually knows how to (self-efficacy), all shape her intentions to seek care from a type of provider in a type of service in a certain location at a certain time for certain cost. Knowing what predicts her behavior will help shape the interventions to change them.

BEHAVIORS SHAPE INTERVENTIONS MEANT TO MAINTAIN OR CHANGE THEM

In other words, demand drives quality of supply. We'd like to steer clear of the "clinic of dreams" approach--if you build it, they will come.

COMMUNICATIONS IS ONE OF SEVERAL INTERDEPENDENT INTERVENTIONS

As I've pointed out, communications can only do so much. Quality of care (which you'll hear about later), cost, access, provider characteristics, availability, product--much of which are marketing terms--are all factors in maintaining or changing care-seeking behavior and therefore benefit from understanding and predicting that behavior. Traditionally, only communications were designed based on behavioral analyses.

LEARN FROM "THE COMPETITION'S" INTERVENTIONS

Women are already seeking and utilizing information, products and services available in the traditional or private service sector, or in the market place that they perceive are giving them the healthiest outcomes at the moment. We can learn from their reasons for behaving that way, lessons that can shape the information, services and products we can provide.

BEHAVIOR CHANGE OF A CLIENT IS DEPENDENT ON BEHAVIOR CHANGE OF THE PROVIDER

If we accept these tenets, that a woman's care-seeking behavior determines the quality of care she will seek, then ensuring that that quality of care is in place (including improved care-providing behaviors) can help encourage and reinforce a woman's care-seeking behavior.

BEHAVIOR MAINTENANCE AND CHANGE IS A SHARED RESPONSIBILITY

Even though we focus on women and their behaviors, husbands, mothers-in-law, peers, the community and providers all play a role and have a responsibility to encourage and reinforce care-seeking behaviors. Behavior, to become routine, needs to be absorbed in workstyles, lifestyles and mainstream.

In closing, some lingering questions about programming emerge from a behavior-driven approach:

--factors influencing health behavior sometimes have nothing to do with health. How can a health project best address these non-health factors;

--a model of behavior change shapes interventions to behaviors, and not behaviors to interventions. How flexible are current projects' timelines and comprehensiveness to accommodate sustainable but long term behavior changes?
--success-oriented environments need to exist for lifestyles, workstyles and mainstream to sustain behavior changes. Sometimes this can be very political, either in the community (e.g., condom access to teenagers, needles to drug users) or in the medical profession (e.g., re-delegation of authority and responsibility; culturalization of protocols and standards). How prepared is a project to deal with political issues in these communities?

Lastly, Mark Twain said: Good judgement comes from experience. And experience comes from bad judgement. I hope we get to share it all in the next few days.

FACTORS THAT AFFECT OBSTETRICAL CARE-SEEKING BEHAVIOR

(PMMN: Ghana, Benin, Nigeria, Sierra Leone)

Socio-cultural:

Knowledge:	Pregnancy not a concern
	Signs/symptoms of complications not recognized
Attitudes about cause:	Woman's insubordination or infidelity
	Evil spirits, will of God, reincarnation
Status of Women:	Education, poverty
	Purdah
	Dependence on external permission, finance, mobility
	Kinship support network and age/seniority
Community Norms:	Stigmatism
	Community management (intrusive or supportive)
Competitive Care:	Self-management
	Prayer; spiritual healers and diviners
	Traditional Birth Attendants, Healers and Herbalists

Accessibility:

Facilities:	Distribution: rural/urban
	Referrals: primary or referral vs. straight to hospital
	Fees (planning; advance payment)
Transport:	Vehicles (fuel, breakdowns, frequency)
	Drivers (night use, main road, refuse emergencies)
	Fees (sliding scale; advance payment)
	Roads (non-existent, impassable)

Availability:

Supplies:	Blood and water
	Medicine, supplies, equipment and beds
Staff:	Waiting time
	Attitude; differences between providers and clients (culture, social, gender)
	Privacy, communication, understanding, sincerity
	Gatekeepers and bribes
	Standards and protocols

FACTORS THAT AFFECT PRENATAL CARE-SEEKING BEHAVIOR IN THE U.S.

SOCIO-CULTURAL:

Knowledge:	Pregnancy natural; not a concern if no problems
Attitudes regarding cause:	Pregnancy denied or unwanted
Status of Women:	Education and poverty Lifestyle (teenager, single parent, abuse) Stressful events (job, moving, relationships) Multiparity
Community Norms:	"Non-mainstream" community and norms
Competitive Care:	Self-management Family member or community provider

ACCESSIBILITY:

Facilities:	Distribution: rural/urban Referral information Fees (understanding Medicaid, payment plans) Childcare services
Transport:	Vehicles Cost

AVAILABILITY:

Staff:	Clinic time; waiting time Attitude; differences between providers and clients (lifestyles, social) Privacy, communication, understanding, sincerity

CONSIDERATIONS WHEN PROMOTING PRODUCT-DEPENDENT, SERVICE-DEPENDENT

OR INDEPENDENT HEALTH BEHAVIORS

LEARN FROM THE COMPETITION

With alternatives: What current behaviors are perceived by individuals to reach the same outcome as the new behavior? Which are more or less effective? More or less efficacious? More or less supported by peers and communities? How can you make the new behavior a part of or a substitute for the on-going behavior?
With consequences: What immediate and longer term consequences does a woman feel as a family member, as a spouse, as a community member if she practices the current behavior? adapts the new behavior? adopts the new behavior?
With products and services: What is the profile of a consumer, non-consumer and possible consumer of health and related products and services? What other products and services (the "competition") are being used? Why are consumers loyal to those products and services? How can you increase your "market share" of consumers? How can you "share" the market?

NEGOTIATE WITH INDIVIDUALS AND THEIR COMMUNITIES

With clients	Realistic behaviors
	Follow-up checks
	Alternative action to address relapses
With providers	Manageable behaviors
	Supervisory support
	Alternative action to address relapses

INTEGRATE INTO MAINSTREAM

Into provider workstyles	Incorporate into standards of practice, management, service design
Into individual/peer lifestyles	Create a success-oriented environment for behavior change
Into community norms	Champion individual lives and community consequences

KEY POINTS OF A BEHAVIORAL CHANGE APPROACH TO REPRODUCTIVE HEALTH PROGRAMS

Understand behaviors before maintaining or changing them

Behaviors shape interventions meant to maintain or change them

Communications is one of several interdependent interventions

Learn from “the competition’s” interventions

Behavior change of a client is dependent on behavior change of the provider

Behavior maintenance and change is a shared responsibility

Quality of Care in Reproductive Health

Barbara E. Kwast, Senior Consultant

Introduction

A response to the 1994 International Conference on Population and Development (ICPD) in Cairo requires that the international health and development community addresses a wider array of reproductive health aspects than ever before. Family planning and maternal and child health (MCH) programs within primary health care (PHC) have been in place for several decades without explicit attention to address maternal mortality and morbidity until the safe motherhood initiative was launched in 1987. The integration of reproductive tract infections, sexually transmitted diseases, HIV and AIDS, violence, fertility and genital mutilation will require a broader approach to program planning and reorganization, involvement of women's and consumer groups and a change in strategy for basic and in-service education of health personnel. Changing medical education and practice to achieve an integrated gender sensitive service with community participation and inclusion of service quality improvement (SQI) present great challenges (Boelen, 1993). International Agencies, Non-Governmental organizations, insurance companies and consumer associations are concerned about quality of care for a variety of reasons, among others, cost-containment and increased output or consumer demand.

Determinants of quality improvement

Inherent in the requirement for quality improvement is the concern with empirical relationships between determinants of quality of care and outcomes. Six major categories for program development need to be considered: 1) political environment; 2) financing; 3) socio-cultural factors; 4) health systems; 5) training; 6) interaction/collaboration. These are all interlocked and if included in a holistic manner can be assumed to impact on integration of services, utilization, health outcomes and sustainability (figure 1). Table 1 shows these six components in greater detail. It is obvious that structure and process components are inextricably linked. Greater emphasis should be on process, where management capabilities are the key to effectiveness (de Winter, 1996; Reerink et al, 1996).

Assessment tools for service quality

Donabedian has directed the assessment and measuring of quality of care in health services against standards developed for the structure, process and outcome of care (Donabedian, 1966). The Bruce framework defines quality of care in family planning in terms of six fundamental elements but it does not include the concept of access (Bertrand et al, 1995; Hardee et al, 1993).

Other assessment tools include:

Facility-based surveys for the assessment of the quality of PHC service delivery (Bryce et al, 1992; Forsberg et al, 1992; WHO, 1990; PRICOR, 1990; Garner et al, 1990); rapid evaluation methodologies for assessing MCH and obstetric services; patient-flow analysis (WHO, 1991); the community diagnosis (CD), situation analysis (SA) and the training needs assessment (TNA) developed by Mother Care; the validation study of self-reported serious maternal and neonatal

complications (Stewart et al. 1995) and population-based baseline surveys; the World Health Organization's (WHO) situation analysis for safe motherhood programming (WHO, 1994); and the WHO and UNICEF guidelines for monitoring progress in the reduction of maternal mortality (Maine et al, 1992).

Barriers to quality of care

Some pertinent findings from the above mentioned analyses and review of other literature (De Geyndt, 1995) highlight major problems in all categories which relate to quality of care. Political decisions and financial policies impact on obstetric indices as shown for example by a 46% decrease in the number of deliveries and a 56% increase in hospital maternal mortality when admissions with obstetric complications trebled in Northern Nigeria after the introduction of the structural adjustment program (SAP) by the Nigerian government (Ekwempu et al, 1990).

Services are often under utilized because of financial constraints. Remoteness and several hours or days walking is a strong deterrent to access. Women's fear and feelings of shame, cultural practices, spiritual beliefs, powerlessness in decision making, people's perception of low quality of services, poor staff attitudes and non-recognition of complications by women and families themselves are barriers to care (Mother Care, 1993; PMMN, 1995). Unintentional distance between provider and client occurs when providers cannot relate to the expectations and beliefs of the consumers (Jaffre et al, 1994).

Quality improvement

Many international agencies and governments are promoting and developing quality assurance in developing countries. A comprehensive overview is contained in the report of the WHO working group on quality assurance (QA), held in Geneva in 1994 (WHO, 1994). Preconditions for sustainable QA are standards which can be formulated for both clinical and non-clinical processes at all levels of the health care system. Standards may be directed toward structure, process and outcome.

The first workshop on quality assurance for midwifery was held by the WHO Regional Office for Europe in 1991. A quality assurance model for Midwifery (QAMID) was reviewed (WHO,1991).

The MotherCare project, John Snow Inc.,funded by USAID, worked on quality improvement in the long-term countries together with national or local governments, NGOs or universities and mostly simultaneously at community and referral level (Winnard, 1995; Kwast, 1995). The overall goal of all projects was to strengthen services, increase knowledge of danger signs in the community, improve clinical and interpersonal communication skills of health workers so as to improve practice at all levels and to attract more women to use health services, particularly for complications. Mother Care II works also in the areas of STDs, post-abortion family planning, micronutrient and female genital mutilation.

The Prevention of Maternal Mortality Network (PMMN) of Colombia University funded by the Carnegie Cooperation (PMMN, 1996) tested a variety of interventions to improve the availability, quality and utilization of emergency obstetric care. These interventions included improving hospital

services and working with communities to mobilize local resources. One of the central premises of the PMM Network is that prompt treatment of serious obstetric complications is the key to reducing maternal mortality in developing countries.

In the majority of LDCs, the focus is on decentralization and strengthening of district health systems with decision-making and involvement of teams in the planning and management of health services. Designing and conducting routine program monitoring and evaluation need to be part of the development of district health systems. Ideally a supervisory mechanism should monitor health workers' performance and improve program weaknesses through a problem solving approach. These issues are all relevant to training efforts within reproductive health.

Training for quality improvement

The Safe Motherhood Initiative (SMI) has provided a wake-up call to urgently address the clinical competencies to handle women with obstetric complications and emergencies at all levels of the health service. The 'Essential Obstetric Functions at First Referral Level' (later renamed essential obstetric care at first referral level) were first defined by WHO in 1986 (WHO, 1991) in an attempt to direct health service managers to the minimum requirements which must be available to save women's lives in an emergency at any referral hospital whether rural or urban, serving at least a population of 500,000. This included requirements for operating facilities, equipment, drugs and supplies and guidelines for the type of health worker who could perform these relevant functions. These surgical and medical treatment functions were selective and included only those which **should not or could not** be performed at health center or village level by health personnel. As the primary health care implementation had paid greatest attention to health center and village level activities, it was now high time to address the hospital functions and responsibilities in a district health system.

The ICM/WHO/UNICEF Pre-Congress Workshop in Kobe, Japan in 1990, agreed that midwives need further education in clinical life-saving skills, research, education, interpersonal communication skills and management (Kwast et al, 1991). A WHO Task Force on Human Resource Development supported expanded areas of midwifery practice for safe motherhood. The International Federation of Gynaecology and Obstetrics (FIGO) advocated in 1991 delegation of responsibilities for essential obstetric functions from gynaecologists to general doctors, medical assistants and midwives where obstetricians are not available to perform these procedures.

WHO developed midwifery modules for safe motherhood and guidelines for prevention of prolonged labor with the pantograph (WHO 1993/1995). The American College of Nurse Midwives (ACNM) produced the life saving skills (LSS) training materials (Marshall et al, 1992).

There is a paucity of distance learning materials for the continuing education of midwives in maternal and perinatal health. South Africa has produced a maternal and neonatal distance learning manual for midwives (Theron, 1997) and also a distance learning program for the advanced diploma of midwifery (DEPAM).

Following the recommendation by ICPD in 1994, that family planning services be expanded and more attention be given to prevention and treatment of STDs, including human immuno deficiency virus (HIV), training requirements and quality of care in FP programs need to be addressed. Staff will need to learn new skills which are now included in a module of the LSS training. There is a concern that staff may become overburdened with the additional STD/HIV prevention and treatment services and that the quality of care in FP clinics may suffer (Fox et al, 1995).

Several countries have started training non-obstetricians in surgical obstetrics. In East Africa, medical assistants who are trained for four years with additional surgical skills, have performed cesarean sections for decades because of unavailability of obstetricians and medical doctors.

Ghana, supported by the Carnegie Corporation, the American College of Obstetrics and Gynaecology and the British Royal College of Obstetrics and Gynaecology (OBGYN), has implemented a postgraduate specialist training for OBGYNs with a 3 months community attachment.

Interpersonal communication (IPC) and counselling skills have received more attention in FP training than in general midwifery training.

New counselling skills will be required for integrated FP/STD services as the two fields differ in choice and treatment options. STD treatment is directive while FP counselling is non-directive providing informed choice to the client.

Community participation does not come automatically and health workers need to be trained how to establish partnerships. "Health workers are the key intermediaries between bodies influencing health policy and target populations. They are the point at which instructions or suggestions are blocked or passed on" (Freyens et all, 1993). A survey of health workers in Rwanda showed that 83% of health workers did not think that it was a good thing if the community took the initiative in health promotion activities.

Measuring quality improvement

Methodologies to measure service improvement after training include knowledge tests, direct observations of client-provider interaction and provider skill assessment but they can be prone to errors and misinterpretation. A peer review process among midwives has recently been started in Indonesia (Quimby, 1996)

Development of protocols takes a great deal of time and is costly. Health personnel may be reluctant to use them if they have not been involved in their development. Many physicians experience protocols as limiting their decision making in treatment and more research is needed about compliance with protocols.

An audit of compliance with antenatal protocols in a district hospital in inner London, showed that only 23.5% of actions dictated by the protocols were actually performed (Yoong et al, 1992).

It is advisable to strive for measuring predominantly process indicators for SM programs as suggested by WHO's Mother and Baby Package (WHO 1994) and the Evaluation Project's final report of the Sub-committee on Safe pregnancy (Koblinsky et al, 1995). Pertinent indicators are: Case fatality rate (CFR) in the hospital; percentage of life-threatening obstetric complications treated in health facilities of all expected complications in a defined geographic population ("met need"); percentage of cesarean sections in hospital of expected C/sections in a defined population; coverage of prenatal and delivery care in a defined population; probably the maternal mortality ratio in the hospital.

Reductions in CFR have been shown in Tanzania from 12.6 to 3.6% over a period from 1984 to 1991 (Mbaruku et al, 1995); in Zaria from 14 to 11% (PMMN, 1996); in Makeni, Sierra Leone, from 32 to 5% between 1990 and 1995 (PMMN, 1996). Significant reduction in hospital morbidity has been shown in Bauchi, Nigeria (Kwast, 1995) and Kumasi, Ghana (PMMN, 1996) after LSS training. The proportion of women with complications requiring hospital treatment ("met need") as reported from rural Zimbabwe was very low (Pittrof, 1997).

Hospital audits and community-based verbal autopsies of maternal deaths are increasingly being performed. However, changes in population- based maternal mortality will not be demonstrable in less than 10 years. Maternal morbidity can be investigated through an audit of maternal "near miss" (Mantel, 1996).

The indicator of perinatal mortality rate (PMR) lends itself to a more sensitive assessment of quality improvement over a shorter period of time (Wilkinson, 1996).

Sustainability

Sustainability is an important issue in all health improvement efforts. It is clear from experience around the world that political commitment as well as political instability are decisive determinants. Improvement of quality in services needs a strong political commitment and allocation of finances, not so much for new buildings but for maintenance of buildings, equipment and vehicles, and for a regular supply of medications.

Collaboration with national, regional and district ministries of health from the early stages of externally supported projects is a requirement for sustainability. Bifurcation of health systems where various ministries or departments are responsible for different areas of reproductive health can lead to fragmentation in services and even competition to attract funding.

Training and in-service education needs to be valued and financed and supported by adoption of regulatory mechanisms to enable health workers to carry out the required tasks. Much of what is at present done in in-service training needs to be incorporated into pre-service training with an added management component for physicians and nurse-midwives. Institutionalizing quality assurance at national level means that governments share the responsibility for effective and efficient professional practice. Unless protocols and norms are adopted and implemented at national level, local efforts are isolated and may not be maintained. The components of QA, peer review and other methods of quality control need to be incorporated into the training of all health professionals.

Leadership and national capacity building for health professionals need greater emphasis to achieve effective building of partnerships with government, communities and other constituencies. This will contribute to sustainability once external support ceases.

REFERENCES

Bertrand JT, Hardee K, Magnani RJ, Angle MA. Access, quality of care and medical barriers in family planning programs. International Family Planning Perspectives. 1995;21(2):64-69.

Bertrand JT, Mganani RJ, Knowles JC. Handbook of Indicators for Family Planning Program Evaluation. 1994. The Evaluation Project. University of North Carolina at Chapel Hill, NC 27516, USA.

Boelen C. The challenge of changing medical education and medical practice. World Health Forum. 1993; **14**:213-216.

Bruce J. Fundamental elements of the Quality of Care: A simple framework. Studies in Family Planning, 1990; **21**(2):61-91.

Bryce J, Toole MJ, Waldman RJ, Voigt A. Assessing the quality of facility-based child survival services. Health Policy and Planning, 1992; **7**(2): 155-163.

De Geyndt W. Managing the quality of care in developing countries. World Bank Technical Paper 258. 1995.

De Winter ER. material resources are not enough: good management is the key to effectiveness. World Health Forum. 1996; **17**:49-51.

Donabedian A. Evaluating the quality of medical care. Milbank Memorial Quarterly, 1966; **44**: 166-203.

Donabedian A. The quality of care. How can it be assessed? JAMA. 1988; **260** (12): 1743-1748.

Ekwempu CC, Maine D, Olorukoba MB, Essien ES, Kisseka MN. Structural adjustment and health in Africa. Lancet, July 7, 1990, p.56.

Forsberg BC, Barros FC, Victora CG. Developing countries need more quality assurance: how health facility surveys can contribute. Health Policy and Planning, 1992; **7**(2): 193-196.

Fox LJ, Williamson NE, Cates W, Dallabetta G. Improving reproductive health: Integrating STD and Contraceptive Services. JAMWA. 1995; **50**(3&4): 129-136.

Freyens P, Mbakuliyemo N, Martin M. How do health workers see community participation. World Health Forum. 1993; **14**: 253-257.

Heidemann EG. The Contemporary use of Standards in Health Care. World Health Organization. Unpublished Document WHO/SHS/DHS/93.2, WHO, Geneva 1993.

Jaffre Y, Prual A. Midwives in Niger: An uncomfortable position between social behaviours and health care constraints. Social Science Medicine; 1995; **38** (8):1069-1073.

Koblinsky M, McLaurin K, Russell-Brown P, Gorbach P.(eds.), Final Report of the Subcommittee on Safe Pregnancy. Indicators for Reproductive Health Program Evaluation.1995. Chapel Hill, North Carolina: The EVALUATION Project, Carolina Population Center, University of North Carolina at Chapel Hill.

Kwast BE, Bentley J. Introducing confident midwives: Midwifery Education for Safe Motherhood. Midwifery,**1**; 1991.

Kwast BE. Building a community-based maternity program. International Journal of Gynecology and Obstetrics 1995;**48** (Suppl): S67-82.

Maine D, McCarthy J, Ward VM. Guidelines for monitoring progress in the reduction of maternal mortality: a work in progress. 1992. UNICEF, New York.

Mantel GD, Buchmann E. Maternal morbidity: a definition for a maternal "near miss". Abstract. Sixteenth Conference on Priorities in Perinatal Care in Southern Africa. 3/11-14 1997, Klein Kariba, South Africa.

Marshall M, Buffington S. Life saving skills manual for midwives. Washington: American College of Nurse-Midwives 1992.

Mbaruku G, Bergstrom S. Reducing maternal mortality in Kigoma, Tanzania. Health Policy and Planning, 1995; **10**(1): 71-78 PRICOR. The evolution of PRICOR's operations research approach. PRICOR Child Survival Report. 1990, **3**(1).

MotherCare. Lessons learned, 1989-1993. Summary final report. MotherCare, John Snow Inc., Arlington VA, 22209.

Pereira C, Bugalho A, Bergstrom S, Vaz F, Cotiro M. A comparative study of cesarean deliveries by assistant medical officers and obstetricians in Mozambique. British Journal of obstetrics and Gynaecology 1996; **103:** 508-512.

Pittrof R. Observed versus expected obstetric complications: an assessment of coverage of obstetric care in developing countries. Tropical Doctors. 1997; **27**: 25-29.

Prevention of Maternal Mortality Network. PMM Results Conference. Abstracts. Accra, Ghana. June 1996. Center for Population and Family Health, School of Public Health, Columbia University. New York, NY 10032 USA.

Quimby HC. MotherCare Life saving skills site preparation, Ulin Hospital and Banjar Baru Hospital, Indonesia January 8-15, 1996. Trip report. MotherCare, John Snow, Inc. Arlington,VA.

Reerink IH, Sauerborn R. Quality of primary health care in developing countries: recent experiences and future directions. International Journal of Quality Health Care. 1996; **8**(2):131-139.

Stewart MK, Festin M. Validation study of women's reporting and recall of major obstetric complications treated at the Philippine General Hospital. International Journal of Gynecology and Obstetrics. 1995; **48** (Suppl): S53-S66.

The Prevention of Maternal Mortality Network. Situation Analyses of emergency obstetric care: examples from eleven operations research projects in West Africa. Social Science and Medicine, 1995; **40**(5): 657-667.

Theron G. The impact of the maternal care manual of the perinatal education programme on the practical skills of midwives. Abstract. Sixteenth Conference on Priorities in Perinatal Care in Southern Africa. 11-14 March 1997, Klein Kariba, South Africa.

Wilkinson D. Avoidable perinatal deaths in a rural hospital: strategies to improve quality of care. Tropical Doctors 1995; **25**: 16-20.

Winnard K. No longer giving life through death. International Journal of Gynecology and Obstetrics. 1995; **48** (Suppl): S7-S20.

World Health Organization. Patient Flow Analysis in Outpatient Clinics. Division of Family Health. Unpublished document. WHO/MCH/91.2. WHO, Geneva.

World Health Organization. Midwifery Quality Assurance. Report of a WHO Workshop, Brussels, 17-20 June 1991. Unpublished document EUR/ICP/HSR 342 (2) 7197B. WHO, Copenhagen, 1991.

World Health Organization. Measuring, developing and mobilizing quality of care. ICM/WHO/UNICEF Pre-Congress Workshop, Vancouver, May 1993.

World Health Organization. Mother-Baby Package: Implementing safe motherhood in countries. Document WHO/FHE/MSM/94.11, WHO, Geneva, 1994.

Yoong AFE, Lim J, Hudson CN, Chard T. Audit of compliance with antenatal records. Brit Med J. 1992; **305**: 1184-1186.

Quality in Reproductive Health Care

David Nicholas, Quality Assurance Project Director

Sometimes, to better understand the present, it is useful to study the past. I'd like to begin by examining the experience in maternal mortality reduction in one developing country. In this country in 1935, the maternal mortality rate was 617 per 100,000 live births. The first graph shows the dramatic reduction of maternal mortality between then and 1955, during which there was significant improvement in the access and quality of care. This experience comes from the United States, Ohio specifically, and we will examine some of the alleged reasons for the improvement in quality that led to this reduction in the MMR a little later. It is important to realize that all countries are developing countries, improving in some areas even while they sometimes regress in others. We can learn much from one another about ways to improve the quality of life.

My topic is quality of care and I will focus on the approaches and methods for achieving it. They are basically the same for reproductive health services as for any other area of care. First, permit me to offer a very simple definition of ***quality care***: quality care is that care which produces the desired and achievable outcomes.

One prerequisite for producing quality care may be a culture in which a majority of staff and clients **care** about quality. A ***quality culture*** is one in which staff view quality as a primary objective of their work and/or value it as a reward in itself, and where clients view quality care as expected because of their culture, their rights as a human being and citizen, or as the payer of care.

There is no one measure of quality because there are many **dimensions** to quality and different **perspectives** on quality depending on the person's position in the system of care (see figures). So, it can be a bit complicated. The best way to assess where one is with quality and to achieve continuous improvement is to have a **systems view** and approach.

The figures show first the general systems model, and then a systems model for a particular service, voluntary sterilization. The Quality Assurance Project takes a broad and comprehensive view of quality assurance and sees it as having three main components: ***quality design, quality control and quality improvement.*** We also stress what we call four tenets of ideal quality assurance:

- Quality assurance is oriented toward meeting the needs and expectations of the patient and community
- Quality assurance focuses on systems and processes
- Quality assurance uses data to analyze service delivery processes
- Quality assurance encourages a team approach to problem solving and quality improvement

I'd like to expand the QA triangle (shown in the next figure) and discuss its components in the context of a QA system and some of the activities and approaches that can be employed to continuously improve and assure quality as shown in the figure. First, let's review some of the ways

in which, what I might call, the "Mothercare Initiative of the nineteen thirties" in the United States led to a dramatic reduction of maternal mortality. Although some of them may be controversial today, according to those involved in the effort at the time the most important factors were:

- The establishment of Maternal Welfare Committees in nearly every state. These committees took "ownership" for improving the systems of care.

- What could be considered a QA monitoring and evaluation activity, and also a process improvement activity: Maternal Mortality Study Committees studied every maternal death to determine the cause and to identify ways in which a similar death could be prevented in the future.

- Improved technology led to two new inputs: (1) the appearance of the first antibiotics in the late thirties: first sulfonamides, then penicillin, (2) the establishment of blood banks in most hospitals

- The acceptance and use of prenatal care

- Increased use of hospital deliveries and the expansion of OB/Gyn residencies and specialists

- Better nutrition guidelines for pregnant women

- Standards of care for maternity hospitals enforced by health departments and the Joint Commission for the accreditation of Hospitals.

- Clinical Guidelines published by the American Society of Obstetrics and Gynecology

One can see that many of these activities correspond to recommended quality assurance activities today. Maternal Mortality has dropped so low in the United States now that few, if any, Maternal Welfare Committees are still operative. However, vigorous quality assurance continues with accreditation of hospitals and health plans, the publication and updating of clinical guidelines, monitoring of the quality of care, outcomes analysis and hospital based maternal mortality and morbidity reviews. Many institutions are also engaged in programs of quality management.

The last figure shows a model of a QA system:

If possible, the best way to begin is with ***Quality Design.*** Quality design is a systematic process for designing new services that identifies the key quality characteristics needed or desired by both external and internal clients, creates design options for those quality characteristics, and then selects the combination of those options that will maximize satisfaction of clients within the resources available. We talked about this process yesterday and its advantages in increasing access, demand and quality. I believe it has been little used until now, but has tremendous potential for improving both quality and demand. The basic steps to be followed are:

1. Define the purpose and clients of the QD effort

2. Determine client needs, desires and expectations
3. Develop product or service features
4. Design operational model
5. Implement model and monitor results

The quality design will ultimately describe the inputs, the processes and their flow and the outcomes desired. At this point the **standards** can be developed if they have not been already. A consensus process is best when possible. Just as important is the effective **communication of the standards**. From the standards are derived the monitoring indicators and **monitoring** process. There are great advantages in **teamwork** in locating ownership and accountability, but even more important, in liberating the creative energy of frontline health workers who can figure out new, ingenious ways of **improving quality** and results. Wherever feasible, **client involvement** in design, standards development, monitoring and problem solving leads to higher quality services, better client satisfaction and the community's commitment and support.

It might be interesting to design a new kind of maternal welfare committee at the district level made up of representatives of women clients, their husbands, community groups, the political administration, physicians, nurses, midwives, and traditional birth attendants. These committees could take ownership for the maternal or reproductive health care system locally. They might be involved in the quality design or redesign of services, monitoring, system improvement and problem solving. The responsibility for assuring access to quality emergency obstetric care, for example, would then become the responsibility of all the partners, not just the health care providers.

Quality assurance is still young. There is much we still don't know. We need to test new ideas and find out which are the most cost effective. There is a great deal of research and trials of new QA approaches going on in the United States and elsewhere in the world, and we have much to learn. Based on the presentations of the "voices from the field" I heard yesterday, some of the of the most exciting innovations will come from countries in Latin America, Africa and Asia.

Definition of Quality Care

Care that produces the desired and achievable outcomes

Culture of Quality

A culture in which **staff** view quality as a primary objective of their work and/or value it as a reward in itself, and where **clients** expect quality as their right as a human being, as a citizen, or as a payer.

Dimensions of Quality

- Effectiveness
- Efficiency
- Technical Competence
- Safety
- Accessibility
- Interpersonal Communications
- Continuity
- Amenities
- Choice

The Marriage of Health and Human Rights

Challenges for Service Delivery *Jodi L. Jacobson, Health and Development Policy Project*

The language of human rights and public health has been merged in the international discourse around population policy and reproductive rights. The application of human rights standards to reproductive health and family planning programs has the potential to transform service delivery. But while advocates have begun to articulate the theoretical bases for the human rights dimensions of women's health, to date relatively little has been done to apply these principles to the complex field of reproductive health care delivery. Methodologies are needed that take the health and human rights discourse beyond theory into practice. This presentation sketches some of the challenges posed by the marriage of human rights and health principles, with a focus on quality of care.

The Push for Human Rights Accountability

As women's movements throughout the world have gained power in recent years, they have undertaken campaigns to gain recognition of women's rights as human rights. In fact, human rights language has become a common thread binding groups with varied agendas in the fields of reproductive and sexual health, economic and social development, and environmental justice. The promotion and protection of individual rights underlies the agenda for women's empowerment in these and other areas.

A central goal of women's rights advocates has been to establish government accountability for violations of women's human rights. These include acts perpetrated by the government or its representatives, such as statutory discrimination or violence against women by public actors. They also include violations by private actors over which the government has jurisdiction. Governments are seen as violating women's rights in the private sphere when, for example, they fail to punish crimes of violence against women in the home or to sanction sexual harassment in the workplace.

Efforts to ensure accountability of outright violations focus largely on traditional human rights methodologies aimed at 1) achieving international consensus on the nature of rights; 2) documenting abuses of those rights; 3) demonstrating state responsibility; and 4) exposing abuses nationally and internationally in the hopes of using public censure or shame to bring about change. (See for example, Orentlicher 1990.) Using the argument that all individuals have internationally recognized rights to bodily integrity, security of person, and equal protection under the law, advocates secured recognition of women's human rights through the agreements resulting from the 1993 World Conference on Human Rights (WCHR), the 1994 International Conference on Population and Development (ICPD), and the 1995 Fourth World Conference on Women (FWCW).

To foster government accountability for promoting and protecting women's human rights, NGOs meticulously have documented abuses in widely disseminated reports, such as those published by the Human Rights Watch Women's Rights Project. (See for example Human Rights Watch 1992, 1993, 1994, 1995). They have compelled governments to document violations of women's rights

worldwide through formal means, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[1] and the U.S. State Department's *Country Reports on Human Rights Practices*. And they have campaigned to ensure that governments take action to promote and protect women's rights.

Public shaming is currently the most powerful tool rights advocates have to foster accountability.[2] In recent years, the collection and publication of data on gender-based abuse, the mobilization of women's rights advocates, and the extraordinary growth of worldwide communications, among other things, have transformed many abuses of women's rights from their previous status of invisibility to intolerable and shameful practices.[3] The *enforcement* of human rights standards through direct sanctions has proved to be a greater challenge, even in cases where the abuses are clear and the culpability of the state is indisputable.[4]

Marrying health and human rights principles and applying these to service delivery presents a new set of challenges. While the language is there, the tools for ensuring the promotion and protection of reproductive rights in service delivery settings has yet to be developed or applied to a given country context or to a specific set of issues. So while a discussion of health and human rights invariably elicits nods of agreement--yes, of course, people have a right to good health and we should find ways to make this operational--examining the issues from the standpoint of practical applications makes clear just how challenging the task is.

For example, what are the strengths and weaknesses of a "human rights" versus a "quality of care" perspective when evaluating health service delivery? What new standards of measurement are needed to ensure programs are consistent with both health and rights standards? What steps are needed to

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[1] The CEDAW committee is comprised of 23 experts who serve in their personal capacity to monitor the implementation of the CEDAW convention, which has now been signed by 160 countries. The United States has *not* signed the convention. The Committee has urged governments to report on the steps being taken to implement the Beijing Platform for Action.

[2] Through the meticulous documentation and widespread dissemination of information on the prevalence of violence against women, rights advocates have undermined the ability of governments to deny the existence of gender-based abuse. Indeed, public shame has been one of the explicit methodologies employed by the human rights communities in dealing with violence. For public shaming to have effect, two conditions are needed: the culprit must have a stake in maintaining a favorable image and must be able to deny the accusations. Documentation of domestic violence and the increasing legitimacy in the international arena of women's right to be free from violence from both intimate partners and strangers have shamed governments into acknowledging the issues and taking action to further document and combat violence.

[3] In Brazil, for example, the women's rights movement lobbied to end the Brazilian courts' acceptance of "honor killings," in which men who kill their allegedly unfaithful wives were acquitted of wrongdoing (Thomas). In Nicaragua, women's groups developed research, media, and campaign strategies to ensure that the government began to address domestic violence (Barroso and Jacobson, 1997).

[4] Rights advocates have argued for diverse means through which to hold states and other actors accountable to women's rights including international war crimes tribunals to investigate the use of rape as an instrument of war, ombuds-people responsible for hearing claims by individuals against states, the inclusion of human rights provisions in international trade agreements such as NAFTA, codes of conduct for industry, and the denial of international assistance to offending governments.

transform family planning programs conventionally measured by the number of contraceptive acceptors or couple-years of protection into programs focused on client needs *and* rights? According to what priorities should resources be allocated for expanding the range of available reproductive health services to be consistent with the fulfillment of a right to health? And how can we ensure that program managers and providers become allies in the promotion of health and rights at the clinic level, and that individual women become more informed and effective advocates for themselves?

Existing instruments of program evaluation and monitoring are insufficient to answer these questions. Human rights theory and methodologies focus on the individual case. While governments and other actors accused of human rights abuses rarely receive notoriety because of a single transgression, it is the protection of the rights of the individual on which the methodologies are based. Public health approaches, on the other hand, are oriented toward communities and populations, focus on prevention of and solutions to health problems on the principle of the greatest good for the greatest number, and use a variety of tools, such as epidemiological and social science research, to identify problems and gauge progress.

Conventional human rights methodologies--such as documentation and shaming--can be helpful in promoting accountability in some areas of health rights. Such approaches may be useful in identifying and censuring governments for obvious violations of women's rights, such as forced abortion or sterilization, or violations of informed consent. But merely documenting and publicizing abuses won't change the provider culture or environment in which such abuses. Nor do such approaches address subtler issues, such as the appropriate range of contraceptive methods that need to be offered in a given context in order to ensure free and informed choice, the responsibility of providers to ensure women understand the need to balance between fertility regulation and the potential risk of infection, or the degree of responsibility of a government to provide an expanded array of services in an era of scarce resources and mounting health needs. Moreover, given the political volatility of reproductive and sexual rights issues, publicizing abuses can simply provide ammunition to political foes of reproductive choice, thereby undermining programs altogether, rather than making them better.

Health, Rights, and Reproduction

The theoretical framework for health- and human rights-based population policies and service delivery programs[5] has been built over many years through the collaboration of women's advocates from every region of the world, and through a growing body of literature. These efforts have ensured that reproductive and sexual health and rights concerns are at least recognized in both international conventions and non-binding conference agreements, such as the ICPD Plan of Action.[6] The goal is to create services that *proactively* empower clients *and* meet their health needs.

Creating such services requires embracing but moving beyond concerns about technical quality and counseling to examine the ways in which provider attitudes, systemic biases, and other conditions may actually be dis-empowering to women and men seeking information and care. While in theory, family planning programs should assist women and men in reducing *unwanted* fertility, the focus in many countries has been on *wanted* fertility, resulting in programs characterized by either outright or subtle coercion of women to adopt methods of fertility regulation, poor quality of care, and an atmosphere in which women's needs for information about and choices of methods of fertility regulation have not been respected or addressed. Moreover, such services largely have not met women's needs for a broader range of services beyond contraception. These limitations are dis-empowering to women and undermine their rights.

Gender power relationships strongly influence women's access to and use of reproductive health services of all kinds. But as research shows, family planning programs often work within and replicate existing power structures in which gender ideologies and social inequities are perpetuated rather than challenged. Available evidence also implies that service providers are more likely to downplay side effects and to limit women's access to information in situations where demographic concerns drive family planning programs, as well as in situations where the social distance between client and provider is great. (See Table 1.)

Research conducted in seven countries by the International Reproductive Rights Research Action Group (IRRRAG) reveals the consistency with which women across cultures and economic classes feel a sense of violation by actors at numerous levels, including the state, the family, and the health delivery system. In an overview of the multi-country IRRRAG studies, for example, the researchers note that 'in regard to existing reproductive health services, women in several of the countries reflected decidedly negative experiences with medical and health providers, as opposed to traditional birth attendants or popular healers, that diminished rather than expanded their sense of entitlement' (Petchesky 1995).

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[5] As a point of clarification, the author holds that the legitimate role of population policies is to create enabling conditions for both the exercise of reproductive rights and the desire for smaller families. These would include efforts to expand women's economic rights, create more equitable arrangements in families, address and prevent gender-based violence and sexual harassment in employment and education, expand access to formal education, and address social norms around gender. The appropriate role of service delivery programs and associated efforts is to address unwanted fertility.

6

Quality of care from a rights perspective

According to the framework developed by Bruce, the six fundamental elements that need to be examined to determine the level of quality of care include choice; information to clients; technical competence; interpersonal relations; follow-up; and the range of services offered (Bruce 1989). Applying a human rights analysis to service delivery, however, assumes that not only should governments provide certain levels of care or provide a wide range of methods or inform women of their risk of infection, or that providers should offer certain pieces of information because it is the right thing to do. Instead, it assumes that they are obligated to do so by virtue of promoting the rights of an individual in these areas. It requires that services be evaluated not only on technical merits but on the degree to which service providers and efforts related to service delivery (such as communications strategies) actively promote individual rights, respect and dignity.

This requires strategies aimed at empowering women by, among other things, informing them of their rights and encouraging them to assert these rights; encouraging them to engage with and ask questions of health professionals; raising their expectations of the level of care they deserve; and challenging gender norms through a variety of community-based strategies in the catchment areas of services. It also requires the application of both quantitative and qualitative methodologies to understand more about client and provider perspectives and their understanding of rights, and about the extent of transgressions of rights at the level of populations.

The case of informed consent in Mexico provides an illustration of some of these approaches. Data from the 1987 Mexican Demographic and Health Survey revealed that ten percent of women sterilized had not been consulted about undergoing the procedure, performed on them in maternity hospitals in the immediate aftermath of delivery. Forty percent of women had not signed a consent form, and were not clear on what the procedure meant (Figueroa Perea 1995). An eight-country UNFPA study of quality of care and contraceptive delivery that included analyses of 24 service delivery points in Mexico in 1995 found that providers were unduly pressuring women to adopt IUDs and sterilization as opposed to other methods (UNFPA 1995). And a 1996 U.S. State Department report stated that most human rights complaints against Mexican health care institutions "involved negligence or abuse during childbirth by medical personnel and charges of forced sterilization." The report goes on to note that "most [forced] sterilizations occurred in public hospitals and were performed on poor and illiterate patients who were not informed of the consequences of medical procedures" (U.S. Department of State 1996).

Women who participated in focus groups in Oaxaca, Sonora, and in Mexico City as part of the first phase of research conducted from 1993 to 1995 in Mexico by the International Reproductive Rights Research Action Group (IRRRAG) made clear their distrust of the government's ability to serve their needs in terms of providing informed consent and informed choice of methods. They also expressed a sense of resignation about having any recourse, formal or otherwise, to protest what they considered to be a violation of their rights with respect to consent and choice in government programs (Ortiz-Ortega 1996).

The Health and Development Policy Project is working with partners in Mexico and the United States to begin to address these issues over the next couple of years. We believe that addressing these issues will require a systematic approach that is supported by both the government and the donors, but that involves grassroots and clinic-based strategies. Our approach is to look at practical applications, and to bring together the public health, human rights, and women's advocacy communities to begin devising workable methodologies, practices, and solutions to these multidimensional issues. Our workplan includes development of a working paper on the ethical and practical dimensions of informed consent within the frameworks of quality of care and human rights, and the development with our colleagues in Mexico of collaborative approaches to this issue.

Among the short-term and long-term steps that we hope will be taken by members of the collaborative include:

- An examination of existing data on the issue of informed consent;

- a review of the Norma Oficial Mexicana de los Servicios de Planificacion Familiar (May 1994) in the context of health, rights, and quality of care issues including informed consent, and in light of the goals and objectives set forth in the new Programa de Salud Reproductiva y Planificacion Familiar 1995-2000;

- initiation of a discussion about the contradictions inherent in the program's concurrent emphasis on meeting targets and ensuring rights and choice;

- efforts to make available to providers the norms regarding informed consent.

- systematic efforts to conduct reproductive rights and consumer rights education among actual and potential clients of the family planning program. These could and should take many forms, including sustained community- or organization-based education campaigns, videos for clients that run in waiting rooms, posters, and the like, enabling women to become better advocates for themselves at the point of service delivery;

- initiation of parallel efforts to develop methodologies/approaches to reproductive health and rights education among providers that would broaden understanding of these concepts, and assist in making providers better advocates for both themselves and their patients within the broader system;

- a review of the existing mechanisms through which formal complaints of abuse can be registered, and at what levels the system fails to function as intended;

- establishing an independent system of monitoring services to measure progress or highlight persistent problems; and

- ensuring that rights and health advocates have a space at the table in important meetings and decision-making bodies.

The first full meeting of the collaborative will take place in October 1997. It is hoped that members of the collaborative will organize a program of future research and data analysis, provider and consumer rights education, advocacy within the Mexican government and advocacy within the donor agencies all aimed at finding workable solutions to these issues *in a way that strengthens and broadens existing services*. We also hope that this work will provide an example to be emulated in other countries where similar changes in services are needed.

This presentation is intended merely to sketch out some of the issues in what is clearly a very complex and nascent field. While the realization of reproductive health and rights will require community-based strategies and multi-sectoral approaches that go beyond service delivery, service providers nonetheless have important roles to play in empowering women and promoting their rights. Developing methodologies and approaches that add a human rights dimension to discussions of quality of care is a good place to start.

***Health, Rights, and Reproduction*:**
Women's Views on Rights, Entitlements, and Service Delivery

Brazil: Mothers in a poor community of Sao Paulo expressed a sense of injustice about the impacts on their lives of social norms that value virginity and sexual ignorance. The standard of care they want for their daughter's bodies includes access to sexual knowledge, protection from STDs/AIDS, and the means to prevent unwanted pregnancy, early marriage and illegal abortions (Petchesky 1995).

India and Pakistan: Recent focus group research has shown that some low-income women in peri-urban areas of both countries have the need for a high degree of secrecy in using methods of fertility control. Women cited the need to balance the discomfort of the methods they use (such as changes in bleeding patterns caused by IUDs or injectables) against the need for secrecy due to fear of retribution from their husbands or in-laws. At the same time, however, they related feeling that service providers were not helpful in assisting them to meet their needs (Kureshy and Snow 1995; Singh and Snow 1995).

Indonesia: Studies show that the family planning program reinforces rather than challenges existing gender norms and social relations based on entrenched patriarchy (Hull and Hull 1995).

United States: Low-income African American women in rural areas of Georgia reported being told they must endure the side effects of NORPLANT because the problems they experienced--weight gain, excessive bleeding, irregular menstruation, and hair loss--might be unpleasant but were 'non-medical.' As such, they were told that Medicaid (the primary health care program for low-income people) would not pay for removal of the device (Petchesky 1995).

Vietnam: In a series of focus groups among women in village areas in Vietnam, women stated that, as the government became more concerned about demographic trends, they felt less and less choice being offered in the family planning program, with the emphasis increasingly on long-acting methods and IUDs (Tuyet, et al. 1994).

REFERENCES

Barroso, C. and J. Jacobson (1997) 'The Policy Agenda for Women's Empowerment in the Next Decade,' paper presented for the International Union for the Scientific Study of Population Committee on Gender and Population seminar on *Female Empowerment and Demographic Processes: Moving Beyond Cairo*, Lund, Sweden, April 1997.

Batliwala, S. (1994) 'The Meaning of Women's Empowerment: New Concepts from Action,' in G. Sen, A. Germain and L.C. Chen (eds.), *Population Policies Reconsidered: Health, Empowerment, and Rights*, Harvard University Press, Boston, pp. 127-138.

Bruce, J. (1989) *Fundamental Elements of the Quality of Care: A Simple Framework*. Working Paper No. 1, The Population Council, New York.

Correa, S. and R. Petchesky (1994) 'Reproductive and sexual rights: a feminist perspective', in G. Sen, A. Germain and L.C. Chen (eds.), *Population Policies Reconsidered: Health, Empowerment, and Rights*, Harvard University Press, Boston, pp.107-123.

Figueroa Perea, J.G. (1995) *Three Comments on Population Policies in Mexico from a Reproductive Rights Approach*. Draft paper for publication, Centro de Estudios Demograficos y Desarrollo Urbano, Colegio de Mexico, July 1995.

Hull, T.H. and V.J. Hull (1995) *Politics, Culture and Fertility: Transition in Indonesia*. December 1995 draft of a paper prepared for the John Caldwell Seminar on Continuing Demographic Transitions, Canberra, August 1995.

Human Rights Watch (1992) 'Punishing the victim: rape and mistreatment of Asian maids in Kuwait.' *Middle East Watch/Women's Rights Project*, Vol. 4, No. 8, Human Rights Watch, New York.

Human Rights Watch (1993) 'Seeking refuge, finding terror: the widespread rape of Somali women refugees in North Eastern Kenya.' *Africa Watch/Women's Rights Project*, Vol. 5, No. 13, Human Rights Watch, New York.

Human Rights Watch (1994) 'Second class citizens: discrimination against women under Botswana's citizenship act.' *Africa Watch/Women's Rights Project*, Vol. 6, No. 7, Human Rights Watch, New York.

Human Rights Watch (1995) 'Neither jobs nor justice: state discrimination against women in Russia.' *Women's Right's Project*, March 1995, Vol. 7, No. 5, Human Rights Watch, New York.

Human Rights Watch (1996) 'Women's Rights Project section.' *Human Rights Watch World Report 1996*, Human Rights Watch, New York.

Jacobson, J. (1995) 'Safe delivery and use of contraceptives: perspectives from the women's health advocacy movement.' Presentation to the Working Group on Reproductive Health and Family Planning, Washington, D.C., October 1995.

Jain, A. and J. Bruce (1994) 'A reproductive health approach to the objectives and assessment of family planning programs', in G. Sen, A. Germain and L.C. Chen (eds.), *Population Policies Reconsidered: Health, Empowerment, and Rights*, Harvard University Press, Boston, pp.193-209.

Kureshy, N. and R.C. Snow (1995) *Women's Preferences for Contraceptive Technology in Karachi, Pakistan*. Draft Field Report.

Moore, K. and J.F. Helzner (1996) *What's Sex Got To Do With It?: Challenges for Incorporating Sexuality into Family Planning Programs.* The Population Council, New York.

Orentlicher, D. (1990) 'Bearing witness: the art and science of human rights fact-finding.' *Harvard Human Rights Journal*, vol. 3, pp. 83-135.

Ortiz-Ortega, A. (1996) 'Grassroots women's perspectives on sexuality and reproduction.' Presentation to the Working Group on Reproductive Health and Family Planning, Washington, D.C., May 1996.

Petchesky, R. (1995) *Negotiating Reproductive Rights: A Seven-Country Study of Women's Views and Practices*. Summary Report, International Reproductive Rights Research Action Group (IRRRAG), Hunter College.

Schuler, S.R., S.M. Hashemi and A.H. Jenkins (1995) 'Bangladesh's family planning success story: a gender perspective'. *International Family Planning Perspectives*, 21(4).

Singh, S. and R.C. Snow (1995) *Udaipur and New Delhi, India: Documenting Women's Perceptions and Preferences for Contraceptive Technologies*. Draft Field Report.

Tuyet, L.T.N. et al. (1994) 'Women's experience of family planning in two rural communes in Vietnam'. *Vietnam Social Sciences*, 39(1).

United Nations Population Fund (1996) *Quality of Family Planning Services*. Evaluation Report No. 8, UNFPA, United Nations, New York.

Annexes

Senior Consultation on Reproductive Health
June 4-6, 1997
JSI Conference Room
1616 N. Fort Myer, 11th Floor, Arlington, Virginia
Agenda

Wednesday, June 4

8:30 - 9:00	Coffee and Pastries
9:00 - 9:15	Welcome and Introductions *Dick Wall, Facilitator*
9:15 - 9:30	Goals and Objectives of Consultation *Elizabeth Maguire, Director of Office of Population*
9:30 - 10:20	Demand Generation: Voices From the Field *MotherCare Field Staff*
10:20 -10:30	Coffee Break
10:30 -12:00	Panel Presentation on Demand Generation *Marcie Rubardt, Community Mobilization Specialist* *Nancy Russell, CEDPA, Nepal* *Kim Winnard, IEC Specialist*
12:00 -1:00	Lunch
1:00 - 1:30	Media Presentation
1:30 - 2:45	Working Groups *Small groups, each lead by a Senior Consultant, will discuss illustrative and working group-generated questions on Demand Generation.*
2:45 - 3:00	Coffee Break
3:00 - 4:15	Working Group Reports and General Discussion
4:15 - 4:30	Wrap-up

4:30	Adjourn

Thursday, June 5

8:30 - 9:00	Coffee and Pastries
9:00 - 9:30	Welcome, Introductions and Review *Dick Wall, Facilitator*
9:30 - 10:20	Quality of Care: Voices From the Field *MotherCare Field Staff*
10:20 -10:30	Coffee Break
10:30 -12:00	Panel Presentation on Quality of Care *Jodi Jacobson, Health and Development Policy Project* *Barbara E. Kwast, Maternal and Neonatal Health Specialist* *Dave Nicholas, The Quality Assurance Project*
12:00 -1:00	Lunch
1:00 - 1:30	Media Presentation
1:30 - 2:45	Working Groups *Small groups, each lead by a Senior Consultant, will discuss illustrative and working group-generated questions on Quality of Care.*
2:45 - 3:00	Coffee Break
3:00 - 4:15	Working Group Reports and General Discussion
4:15 - 4:30	Wrap-up
4:30	Adjourn

Friday, June 6

8:30 - 9:00	Coffee and Pastries
9:00 - 10:15	Recommendations on Demand Generation and Quality of Care
10:15 -10:30	Coffee Break
10:30 -12:00	Discussion
12:00 -12:30	Concluding Remarks *Joseph Taylor, Department of Obstetrics/Gynaecology, Central Hospital, Koforidua Central Region, Ghana*
12:30	Adjourn

Discussion Questions

Senior Consultation on Reproductive Health
June 4, 5, & 6, 1997
Illustrative Discussion Questions

Quality of Care

1. What are the components of QOC for reproductive health? eg:

- acceptable level of provider skills, both technical and IPC
- necessary/desirable mix of services
- culturally appropriate care
- accessible care
- timely services
- available drugs and supplies
- coercion free care
- appropriate treatment dialogue

What models exist?

2. Can we talk about QOC without discussing "quality of life" issues that include consideration of the opportunity costs of accessing and utilizing services? How are we measuring client satisfaction with services?

3. What are the various approaches to improving and maintaining the quality of RH services?:

- development of treatment standards, protocols and curricula
- training; in-service, pre-service; competency-based; team approach, etc
- accreditation, licensure, certification
- peer review through professional societies
- organizing/strengthening of informed/entitled consumer groups/women's groups
- quality assurance methodologies
- improved HIS/MIS systems
- user fees

4. How is quality best monitored? Chart/records/register reviews? Peer review? Maternal and neonatal death audits? Client exit-surveys? CFR? Indicators?

5. What indicators are useful in monitoring/evaluating QOC? What has been the experience to date with various indicators?

6. How can interventions to improve QOC become sustainable? QA? Supervisory systems? Peer-review? Certification/recertification? Pre-service education? Continuing medical education (CME) Informed/empowered consumer groups? What examples do we have?

7. Is improving the quality of services sufficient for increasing demand? Examples?

8. What policy recommendations are key to improving and maintaining QOC?

Demand Generation

1. What are the most common/significant causes of underutilization (based on qualitative research?

2. How have programs (models) addressed each of these causes?

3. Is IEC sufficient to increase utilization? Which techniques are most cost-effective?

4. What have been some of the most successful models for increasing demand:
   - working with women; women's groups; community/consumer groups; men; youth groups; religious/leaders; employers; school children; other stakeholders?
   - providing workplace/school services; mobile units; community-based workers?
   - IEC campaigns: radio; TV; theater; endorsements by politicians, celebrities; sports events, national holidays, etc?
   - improving QOC?

   Is this demand sustainable?

5. What have been the most successful multi-sectorial approaches: micro-credit; savings clubs; literacy classes; girls education; agricultural coops?

6. Are community mobilizing approaches, eg, PRA, Autodiagnosis, etc., successful in increasing utilization? Cost-effective? Sustainable?

7. Is an integrated approach to reproductive health services more attractive to women than traditional FP/MCH services? Does this approach increase demand? Consumer satisfaction? Lessen opportunity costs?

8. What role does IPC training for providers have on increasing demand?

9. Will increased utilization result in better health outcomes? Examples?

10. How can we increase knowledge and use of self-care, preventive measures?

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MotherCare Meeting Recommendations

MotherCare Quality of Care Meeting
June 2 - 3, 1997

MotherCare hosted a two-day Quality of Care meeting to explore questions related to the training of midwives and obstetrics. The discussion focused on three major training and service related issues:

- determination of provider skills and function by category of provider; approaches to building provider teams;
- approaches to developing and sustaining providers skills through in-service and pre-services training courses; and,
- moving training into improved service delivery.

MotherCare invited a select number of midwives and obstetricians with experience in MotherCare long-term countries as well as those with other developing and developed country experience. Seven of the participants were assigned to each issue and were asked to prepare a paper on that topic. This format lent structure and focus to the discussions, maximizing the contributions of the presenter as well as stimulating participant discussions. Summaries were made following each discussion. The participants reviewed all summaries and closed the meeting with specific recommendations. These recommendations were delivered by Barbara Kwast at the USAID Senior Consultation on Reproductive Health.

Recommendations

1. There is a need for projects to work through an in-country coordinating body that determines the needs for maternal and child health priorities, taking into consideration available resources and expectations for the community. That body should include members of all relevant ministries, professional organizations, NGOs and community/ consumer groups. International and bilateral agencies should work through this body.

2. In order to improve quality of services a systematic approach needs to be taken which includes:

    - formulation of policies, standards and protocols with involvement by all stakeholders from the outset.
    - the policies and standards will then determine the role and functions of service providers at all levels.

- these will in turn dictate the content of curricula for both pre-service, in-service and post graduate training.

Within these broad recommendations, the group wants to underscore the following:

a. Countries should be supported in identifying the issues pertaining to training so that they have ownership and accountability for results.

b. MOH and Min. of Education, Councils and professional associations should cooperate to meet continuing education requirements which recognize the need for life-long changes.

c. Evidence-base standards need to be incorporated into pre-service and in-service training.

d. Pre-service improvements need to be addressed as low quality of service providers cannot adequately support increased competencies of providers through in-service training.

e. For in-service training to become sustainable it needs to be built on improved quality of service providers.

f. Pre-service and in-service training need to be competency-based and include a community component, including biological, behavioral, epidemiological spheres for a process for life-long learning.

g. Set up OB/GYN specialist training in-country, with post-qualification opportunities out-of-country.

h. Pre-service training should be improved, as in-service training has been used as a way of providing training that should have been part of the pre-service curriculum.

i. For pre-service training to achieve the required standard, the training of trainers needs to be assessed and improved in order to create master clinicians in current practices and educational methodologies.

3. Team building and expansion needs to be addressed through team problem-solving workshops or in-service training as a measure to enhance communication and understanding and mutual respect within the service delivery network.

4. Interpersonal communication skills training is a prerequisite in all training efforts to facilitate provider-provider and provider-client interaction.

5. Promotion of professional leadership, OBGYN, midwifery and nursing, needs to be advocated through research opportunities and management/administrative training.

6. Appropriate monitoring and evaluation techniques need to be implemented based on quality data collection systems for the use of monitoring and evaluation of service delivery. Examples for evaluation are peer review, maternal/perinatal audits, analysis of "near miss", change in coverage, case fatality rates and unmet need in cesarean section and treatment of complications.

7. In order to improve measurement of impact in reproductive health outcomes, USAID Washington and Missions need to recognize that a long term approach over a ten year period is required.

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